

REVISED MINUTES
(Approved by the Task Force)

HEALTH CARE TASK FORCE

September 16, 2008
Capitol Annex, Boise, Idaho

The meeting was called to order by Cochairman Senator Dean Cameron at 1:40 p.m. Other Task Force members present were Cochairman Representative Gary Collins, Senator Joe Stegner, Senator Patti Anne Lodge, Senator Tim Corder, Senator John McGee, Senator Elliot Werk, Representative Sharon Block, Representative Jim Marriott, Representative Carlos Bilbao, Representative Fred Wood, Representative Margaret Henbest and Representative John Rusche. Senator John Goedde was excused. Staff present were Paige Alan Parker and Juanita Budell.

Others present at the meeting were Kathie Garrett, Partners In Crisis; Roger Seiber, Mountain View Hospital and Riverside Medical Center; Stephen R. Thomas, Idaho Association Health Plans; Dede Shelton, AARP; Bill Deal, Idaho Department of Insurance; Teri Woychick, Dora DeCamp, Lisa Hines, Heather Taylor, Stacey Zuchelkowski, and Rebecca Schattin, Boise State University; Woody Richards, Intermountain Hospital; Susie Pouliot, Idaho Medical Association; Heidi Low, American Cancer Society; Representative Phylis King, District 18; LaDonna Larson, Idaho Health Data Exchange; Barbara Lenaghan and Corey Surber, Saint Alphonsus Hospital; Julie Taylor, Blue Cross of Idaho; Martin Bilbao, Connolly & Smyser, Ctd.; Mark Browning, State Board of Education; Toni Lawson, Idaho Hospital Association; Kathleen Allyn, Dick Armstrong, Leslie Clement and Paul Leary, Idaho Department of Health and Welfare; Amy Holly Priest, Business Psychology Association; Molly Steckel, Idaho Medical Association and Idaho Psychological Association; Lyn Darrington, Regence Blue Shield of Idaho and Business Psychology Association; Tom Howes, Idaho Health Underwriters; Julie Robinson, Idaho Voices for Children; Roger Madsen, Idaho Department of Labor; Mr. Ed Baker, Director, Center for Public Health, Boise State University; Mr. Ben Diederich, Milliman; and John Watts, Veritus Advisors.

A motion was made by Representative Bilbao for approval of the August 20 and 21, 2008 minutes, seconded by Senator McGee. The motion carried by unanimous voice vote.

The first speaker of the afternoon was **Mr. Mark Browning**, Chief Communications Officer for the Idaho State Board of Education. He provided an update on student health insurance policies in Idaho public post-secondary institutions. (A copy of **Mr. Browning's** handout is on file in the Legislative Services Office). Among the points made by **Mr. Browning** in that presentation were:

- Currently, the policy in place mandates that all students attending an Idaho institution of higher learning (BSU, ISU, UI, LCSC and Eastern Idaho Technical College) must have health insurance coverage.
- Private institutions of higher learning and the three community colleges are NOT required to adhere to the policy.
- The mandatory health insurance policy was implemented by the State Board of Education on July 1, 2003.
- The policy adopted by the State Board provides minimum direction to the institutions. Each institution may, at its discretion, adopt more stringent requirements. However, institutions are HIGHLY encouraged to work together to provide the most cost-effective coverage possible. Whatever requirements adopted by each institution must be in accordance to state and federal law.
- An institution may allow a student to “opt out” of the Student Health Insurance Program (SHIP) if the student provides evidence of current coverage that is equal or greater to what is offered through the school. This became somewhat easier for students to do thanks to the passage of Senate Bill 1105 (2007), which expands the definition of ‘dependent.’ Under the new law, unmarried non-students can remain on their parents’ insurance until the age of 21 and unmarried, financially dependent, full-time students can remain on parental insurance until the age of 25. Unmarried children designated as disabled can remain a dependent for insurance purposes up until any age.
- Since the Board’s last report to this Task Force in August 2007, the State Board has formed a committee to work on the issue of coordinating a single provider for all of the colleges and universities. The Board has assigned ISU Financial Vice President James Fletcher to lead this effort. Mr. Fletcher has indicated that the group is active; they have met and are working on gathering information.
- This committee is looking at what would be necessary for a provider to do in order to comply with the bid process and still be within Board policy and State/Federal laws. The committee is working with several insurance companies including (and not limited to) Blue Cross of Idaho. This group is to report back to the Board with preliminary recommendations in December, and with final recommendations by February 2009.

Representative Wood said there was a marked difference in the benefits provided by various insurance carriers and inquired if there have been any significant changes. **Mr. Browning** replied that there were no major changes, just some minor ones.

Cochairman Cameron asked **Mr. Browning** to take a message to the committee that the Task Force is ready to help them in any way, as the goal is to have better student health insurance coverage for less money. He thanked **Mr. Browning** for his report.

The **Cochairman** then asked **Senator Stegner** to report on the status of the mental health transformation project and the WICHE report.

Senator Stegner said the process is continuing as more information is being provided to stakeholders. The WICHE team reported on September 16, 2008, to the Governor's Select Committee on Health Care. **Senator Stegner** thinks that the Select Committee was impressed by the concept of the two major proposals and expressed support for the process. The WICHE team will report September 17, 2008, to the Interagency Committee on Substance Abuse (ICSA) and the same response is expected. However, ICSA has not yet taken up the idea of acting as the transitional work group. **Senator Stegner** said that he hopes to have more feedback by the Task Force's October meeting.

Cochairman Cameron thanked **Senator Stegner** and the Mental Health Subcommittee for their work on this issue.

Next on the agenda was **Ms. LaDonna Larson**, Executive Director of the Idaho Health Data Exchange, who presented a PowerPoint program, a copy of which is available in the Legislative Services Office. Information from that presentation included:

- The goal of the Health Quality Planning Commission is the implementation of health information technology to allow quick, reliable, secure access to health information and to promote patient safety and best practices in health care.
- To date, the Commission has studied health information technology, assessed existing health information technology, analyzed national trends, planned for implementation of a health data exchange, and identified need for a corporate entity.
- The Idaho Health Data Exchange is a 501(c)(6) non-profit corporation with funding from all major players. Patient and provider participation is voluntary.
- Patient information will be protected.
- The Idaho Health Data Exchange has engaged a business partner, Axolotl, to provide a proven solution at a reasonable cost. This solution has been implemented in Santa Cruz, California (1996), Cincinnati, Ohio (2000) and Grand Junction, Colorado (2005).
- The technology utilizes push/pull technology. Push - Clinical information delivered to physician of record by labs, facilities, other physicians and pharmacies; Pull - query of clinical information to other data sources.
- Electronic medical records (EMR) Lite system includes demographics, medications, allergies, diagnoses, lab results, radiology reports, encounter recording, e-prescribing, workflow automation, electronic storage of patient records, document generation and secure messaging.
- A five-year roll out is planned. Beginning in November 2008 - three hospitals. Subsequent phases will result in participation by 30 hospitals, 10 independent data sources and 1,500 physicians.
- Privacy and security policies align with HIPAA and provide that access is limited to authorized users, the level of access is based on user's role, patients can "opt-out" and the system's architecture makes it secure.
- The system will improve quality, enhance patient safety and reduce costs.

Senator Werk said that some physicians already have some type of electronic records and inquired if EMR Lite is a “layer” that will fit with those existing systems. **Ms. Larson** said that it will “enhance” a physician’s electronic investment and that the system is meant to be seamless.

Representative Marriott inquired about the cost to physicians who already have some type of electronic medical records system. **Ms. Larson** said the cost would be \$390 per physician per year. For the physicians who do not have a system in place, the ERM Lite would cost \$770 per physician per year. **Representative Rusche** related that if a physician were to purchase a system, it would cost about \$10,000, and thinks that what **Ms. Larson** is representing is a good deal.

Representative Henbest said she appreciated the presentation and thanked **Ms. Larson** for the progress that is being made.

Representative Marriott said this is a gigantic step forward and will present some great opportunities. He said that he is glad the information will not be stored in a data bank, but did inquire about an index. **Ms. Larson** said there is a master patient index. **Representative Marriott** asked if insurance companies will have access to information so that claims can be paid. **Ms. Larson** said that physicians offices’ will be able to “push” that information to the insurers.

Mr. Ed Baker, Director of the Center for Public Health at Boise State University, was the next speaker. He said that the Center had been asked to provide information on modeling for an analysis of various alternative premium assistance programs to the Idaho Department of Health and Welfare through a contract with the Idaho Division of Medicaid. Boise State was the prime contractor and a team was put together with Milliman, an international actuarial group, which provided actuarial and modeling support. **Mr. Ben Diederich**, from Milliman, was the prime author of the final technical report, and joined the Task Force, by telephone, following **Mr. Baker’s** comments.

Mr. Baker’s report, “Policy Option Research for Premium Assistance Programs”, consisted of a PowerPoint presentation, a copy of which is available in the Legislative Services Offices. This presentation included:

- The purpose of the research was to provide information and model support for the analysis of alternative premium assistance programs to the Idaho Department of Health and Welfare. The research team consisted of Boise State University Center for Health Policy, Milliman, Inc. and Kate VandenBroek.
- The research tasks were to evaluate the premium assistance programs implemented in six comparison states for possible adaption in Idaho, model the subsidy and operational cost requirements for each of the six

adapted models, and evaluate the “fit” of various model components relative to the specific characteristics of Idaho.

- The premium assistance policy objectives are: cost savings (reduce state-funded cost of Medicaid enrollees by utilizing employer-offered insurance programs as a replacement of traditional Medicaid benefits and full state funding); coverage expansion (reduce the number of uninsured by creating or expanding the subsidy-eligible population, generally low-income individuals not eligible for Medicaid, with the goal of making private health insurance more affordable) and informed choice (provide a Medicaid enrollee the opportunity to select a commercial health insurance program over traditional benefits while ensuring coverage without benefit restrictions).
- The comparison states were: Oregon (Family Health Insurance Assistance Program); Michigan (Access Health); Utah (Utah’s Premium Partnership for Health Insurance); Maine (DirigoChoice); Illinois (Family Care/All Kids Rebate); Pennsylvania (Health Insurance Premium Payment).
- Pure Premium Assistance Models (directly comparable to Idaho’s Access programs) are: Oregon, Utah and Illinois.
- Other models would require significant changes to Access programs or models additional to the Access programs.
- The “subsidy model” is based on a hypothetical introduction of a comparison state’s program in Idaho. Considerations include:
 - Oregon - high total costs due to high expected enrollment and high subsidy costs (especially for lowest income enrollees) with a good marketing program and stable environment.
 - Michigan - estimates are from preliminary analysis from Northern Idaho Health Network for five northern counties of Idaho implementing a Muskegon-like three share model.
 - Utah - lower number of enrollees since program requires that an individual be eligible for employer coverage but not enrolled and a flat dollar subsidy.
 - Maine - subsidy costs are high, especially for enrollees in the lower income ranges, with overall enrollment high with much less restrictive eligibility requirements (designed to work with Dirigo Medicaid which made isolating the cost of the premium assistance program difficult).
 - Illinois - enrollment low due to smaller subsidy and more restrictive enrollment criteria (adults can enroll only if they are parents of eligible children).
 - Pennsylvania - open only to Medicaid eligible individuals so comparisons difficult, generous subsidy mitigated by employer coverage requirements.

- The “operational model” is based on a hypothetical introduction of a comparison state’s program in Idaho. Considerations include:
 - Administrative costs per participant vary widely.
 - Maine - most of the administrative costs delegated to the insurance carrier.
 - Pennsylvania - decentralized model creates high fixed costs which are spread over a low projected Idaho enrollment.
 - Cost per participant per year for programs with high fixed costs will be expected to decrease over time as membership grows and fixed costs are distributed over more enrollees.
 - Variable costs will increase over time with membership growth.
 - Michigan - actual expenses for Muskegon County estimated and not adjusted for Idaho population characteristics.
- “Fit” considerations are complex, would require substantial discussion outside the time limitations of this presentation.
 - In general, the Oregon, Utah and Illinois programs “fit” better with the current Idaho premium assistance program and are generally consistent within Idaho political realities.
 - The Maine and Pennsylvania programs would require substantial political will to introduce in Idaho as they would require substantial system changes.
 - The Michigan Muskegon County model has been studied in Idaho in the past as a method to decrease the number of uninsured in Idaho and a feasibility study was being conducted at the time of the submission of this study sponsored by the North Idaho Health Network.
- Other considerations include:
 - Waivers:
 - Oregon, Utah and Illinois Medicaid waivers documents included in the report.
 - Health Insurance Flexibility and Accountability (HIFA) demonstration proposals under Section 1115 waiver authority used for the above states.
 - Unique development process for each of the three HIFA waivers makes it difficult to draw broad conclusions about how Idaho would proceed.
 - Michigan, Pennsylvania and Maine did not have waivers for different reasons.
 - Funding:
 - Health Insurance flexibility and /Accountability (HIFA) demonstration proposal serves as the recommended process for accessing federal funds.
 - State and county indigent funds.
 - Disproportionate Share Hospital (DSH) payments.

- Tobacco Settlement funds.
 - State Insurance fund.
 - General revenue.
- Overall assumptions of the study:
 - Overall state population growth was not considered;
 - Health care cost inflation was included in modeling;
 - All projections assume a total replacement of the existing Idaho premium assistance program;
 - The operational model assumed no additional savings from replacement of current programs; and
 - Enrollment growth was assumed to be linear over the five-year period.
- Overall limitations of the report:
 - The report should be used by the State to understand the approximate magnitude of enrollees and program costs of implementing various premium assistance programs in Idaho and may not be suitable for other uses.
 - BSU and Milliman, Inc. have relied on data and information from many sources such as the U.S. Census Bureau and have not audited this data for accuracy but have reviewed them for reasonableness. Inaccurate or incomplete data may require a revision of the values and conclusions of the study report.
- Report summary:
 - Premium assistance programs vary across comparison states in their focus, implementation and cost.
 - Idaho projected participation rates, subsidy costs and administrative costs vary by premium assistance program implemented.
 - “Fit” considerations suggest that the Oregon, Utah and Illinois programs may provide options for adjustments to the current Idaho Access Card program while the Michigan Muskegon County program may allow for a new look at expanding the privately insured base of Idaho.
 - Premium assistance programs may be able to increase the privately insured base of the state while maintaining, and in fact supporting, the private health care insurance market.

Following **Mr. Baker’s** presentation, a telephone conference call was placed that allowed **Mr. Diederich** to answer any technical questions.

Ms. Leslie Clement, Administrator of the Medicaid Division of the Department of Health and Welfare, agreed to provide copies of the report that was requested by **Cochairman Cameron**. **Ms. Clement** also said that the CHIP program for children is coming up for reauthorization by Congress in April 2009. Presently, the program is operating on an existing budget which is fairly limited. She suggested that timing of changes, that relate to Congressional action, be considered. **Ms. Clement** reviewed updates and will provide them to the Task Force. DSH (Disproportionate

Share Hospital) is available to those who meet certain criteria. Idaho is considered a low DSH state and only the annual increase was used in 2007 - 2008, which was \$2 million.

Cochairman Cameron asked **Mr. Diederich** if most of the plans that they reviewed were funded by general funds and whether the financial stability of the various states had been considered. **Mr. Diederich** replied that Milliman didn't look specifically at what financial instability would be created by any of the programs. However, the majority of funding was from general funds.

Cochairman Cameron stated that a copy of the full report could be obtained from **Mr. Paige Parker**, Legislative Services Office. The Cochairman also made three requests of **Mr. Parker**. (1) The report be posted with the minutes; (2) The information on the charts (in the presentation) be enlarged for easier reading; and (3) Data on New Mexico, Washington, Oklahoma, and New York be made available to the Task Force in regard to the Premium Assistance Program: what are they doing, how they are doing it, how it is funded, and some of the basic information. **Cochairman Cameron** thanked **Mr. Diederich** and **Mr. Baker** for talking to the Task Force.

The Cochairman stated that he thinks one of the items that should be discussed before the legislative session begins is whether there should be any improvements or changes to either the Access Card or Access for Health Insurance. He expressed the view that there are some things that can be done without affecting the budget.

Senator Werk inquired if information was available regarding the funding source for premium dollar reserves (premium tax). The answer was "yes".

Cochairman Cameron then welcomed **Mr. Roger Madsen**, Director, Idaho Department of Labor, who will talk about the Nursing Workforce Center progress. A copy of his prepared remarks is available from the Legislative Services Office. **Mr. Madsen's** statement included:

- Idaho is facing a shortage of nurses, which nationally, is projected to become critical between now and 2020.
- Nursing comprises the largest segment of health care providers.
- If nothing is done right now, we will not have enough nurses to meet the health care needs of our residents.
- To address this issue, the Idaho Legislature created the Idaho Nursing Workforce Advisory Council in 2007 and asked the Department of Labor to assume the responsibility for conducting the research funded by a federal grant to the Idaho Alliance of Leaders in Nursing.
- Originally, the Idaho Nursing Workforce Center was located at Boise State University. When the 2007 legislation was extended, the responsibility shifted to the Department of Labor. The research is now being conducted by Labor's Communications and Research Division at the direction of an advisory council.

- Initially, the fiscal impact was \$358,100 over two years. The research is approximately one-third of the way through the second year. Expenditures are expected to be slightly more than \$287,000 when the legislation sunsets on June 30, 2009.
- The Department of Labor has thoroughly researched the projected demand for nurses including wage and education levels. An ongoing survey of postsecondary nursing program directors will provide supply and educational capacity information. In a few short weeks the Department should have all the data necessary for statistically assessing the magnitude of what many believe is a severe nursing faculty and nursing work force shortage statewide and will be able to define it by region. Coupled with the ability to track employment through Social Security numbers, information will be able to identify where the students enrolled in specific programs choose to work and where they stay over time. This kind of information will help answer questions such as:
 - Do online education programs encourage nurses to remain in rural communities; and
 - Does increasing enrollment through program expansion result in students remaining in those communities or do we lose them to out-of-state recruiters in border communities?
- A final report and recommendations will be delivered to Governor Otter in December and will allow the State Board of Education and the Legislature to make informed, data-driven decisions about the most effective use of limited state resources for dealing with Idaho's nursing faculty and work force shortage.
- Preliminary conclusions are:
 - Between 2006 and 2016, health care will be among the state's fastest-growing, largest and highest-paying industries.
 - Idaho has fewer nurses per capita than any surrounding state but Nevada.
 - Forty percent of Idaho's nurses are over the age of 50, and 80 percent are over age 35.
 - Given our current nursing forecast, we project a need for at least 5,300 new RNs and 1,400 LPNs for a total of 6,700 nurses by 2016. On average that means Idaho will need more than 500 new RNs and 140 LPNs for a total of 640 nurses every year. These figures do not include chronic vacancies, which an Idaho Hospital Association survey currently estimates to be around 300 positions.
 - Our current lack of capacity - which includes a lack of nursing faculty, classroom facilities and clinical facilities for gaining on-site experience – forced Idaho's nursing program directors to deny admission to 865 qualified Idaho students for the 2007-2008 academic year.
 - Within Idaho's nursing education system, 90 percent of the faculty is over age 40, with 25 percent planning to retire in the next five years.
 - Low faculty salaries and limited opportunities to become nursing educators are major barriers for preparing nurses for the future.

- All this at a time when we know Idaho's population age 55 and older will increase nearly 50 percent in the next eight years.
- In conclusion:
 - Nursing will be the state's hottest job for the next decade. Nursing pays well – the median wage right now is \$25 per hour – and nurses are and will continue to be in great demand in the foreseeable future in Idaho and in America.
 - Our aging population means health care in general should be a major concern for Idaho and something policy makers must address from a broader perspective. There is great concern in our acute and long term care facilities that Idaho is not producing enough nurses to take care of our aging population.
 - Several efforts are underway to construct educational buildings and expand nursing education facilities without assured funding for faculty and staff.
 - The Department of Labor's 25 local offices have already made training health care professionals a priority. Nursing currently accounts for the single largest share of occupational training funded by the Department of Labor using Workforce Investment Act funds. Over the last several years nearly \$1 million has been provided by the Department to help 214 people pursue a nursing occupation.
- The findings from this research effort will help industry and policy makers:
 - Address Idaho's current nursing faculty and work force shortage;
 - Initiate changes to better retain nurses in the work place and in particular, retain older nurses;
 - Fund state educational facilities and the faculty necessary for educating nurses;
 - Develop residency programs that allow nurses to transition to professional status.
- The original charge to the Nursing Workforce Advisory Council and the Department will be fulfilled by the end of this fiscal year, including:
 - Accurately assessed the supply and demand for Idaho nurses by region;
 - Established cooperative agreements for sharing licensing board data that could be expanded for similar occupations such as pharmacists, radiologists and other health care occupations;
 - Established a \$100,000 scholarship fund co-sponsored by the Idaho Workforce Development Council and the Idaho Alliance of Leaders in Nursing for students obtaining post-graduate degrees in nursing and who commit to becoming academic faculty or work in rural hospitals for three years;
 - Automated and improved the Idaho Board of Nursing's system for gathering information from the state's nursing education institutions on this occupation;

- Developed in-house expertise with the ability to tackle health care work force issues at a broader level;
- Surveyed the medical industry and capture planned facility expansions and occupational demands for work force needs in other non-hospital settings including long term care, doctor's offices and clinics;
- Asked the State Board of Education for nursing graduate Social Security numbers and with their permission, use those numbers to geographically track nursing employment and retention trends;
- Developed strategic initiatives between industry, education and labor to grow and sustain Idaho's nursing work force; and
- Finalized the council's strategic plan and delivered a set of recommendations to Governor Otter.
- Building on the base and maintaining the initial research will require about \$90,000 per year - half of what was originally provided - and will allow the state and the health care industry to:
 - Update data projections necessary for assessing the state's ability to meet work force demands;
 - Track the ability of Idaho's nurse education programs to meet industry needs and the effectiveness of any program expansions;
 - Monitor regional trends in nursing employment including new graduate turnover in their first and second years of employment; and
 - Prepare to accumulate and analyze data for the broader health care work force.

Mr. Madsen related that the Department of Labor has been told by the Governor's Office to "zero-in and focus solely on nursing." However, he believes that the research being completed for nursing will be invaluable for the other critical health care occupations as Idaho copes with the issue of health care delivery in the years to come. Medical facility expansions are in the planning stages for nearly every corner of this state – from Coeur d'Alene to Preston. Idaho's population of seniors 65 and older could double by 2016, intensifying the demand for health care and underscoring its status as one of the state's top industries and economic contributors. Employment in health care should grow by more than 42 percent between 2006 and 2016 – more than twice as fast as the overall economy.

Mr. Madsen stated that the Department of Labor is working with the Idaho Department of Correction on a wage analysis for the occupations it will need – psychiatrists, psychologists, psychiatric nurses and skilled social workers – to operate its new 300-bed mental health hospital. Also, the Department's Lewiston local office is helping the Lewiston Veterans Home cope with a shortage of nurses, health care aides and other workers.

Mr. Madsen concluded by respectfully requesting that the funding sunset be extended. He stated that the investment will allow the Governor, the Legislature and the State Board of Education to direct limited resources where they are most needed and measure the effectiveness

and progress of the state's efforts to address this critical issue. **Mr. Madsen** provided three handouts - Governor Otter's Nursing Workforce Advisory Council Update, Idaho Hot Jobs, and Idaho Hot Industries. These materials are available in the Legislative Services Office

Representative Marriott asked what the private sector is doing regarding the training of nurses. **Mr. Madsen** replied that the Idaho medical community is very supportive and it is doing the best that it can. **Senator McGee** said that West Valley Medical Center in Caldwell has a program called "Grow Your Own," where people working in the hospital are eligible for tuition for education to advance their skills.

Representative Block said that she appreciated the work being done, but wanted to mention the shortage of help in the areas of substance abuse prevention and treatment.

Representative Henbest said that within the private sector, the Advisory Council has been heavily focused on data, making sure it has accurate numbers. The Council is also looking at what hospitals can do to retain their nurses, as well as retaining faculty for nursing education.

Mr. Madsen stated that he is aware of a program being pursued by a local hospital where notices were sent out to all nurses who were no longer working, asking them to return. He feels there has been some success.

Senator Stegner referred to the WICHE report which made projections through 2025 and provided data regarding the surrounding states, Western states, and the immediate area. He said that every state is facing the same work force projected shortage in the future, with the exception of California. The Senator inquired whether the Department has looked at developing a program to entice the surplus of people in California to move and work in Idaho. **Mr. Madsen** said the Department has considered it.

Cochairman Cameron thanked **Mr. Madsen** for his report. **Cochairman Cameron** announced that the next Task Force meeting will be held on October 23, 2008. Legislative recommendations will be taken and analyzed at the Task Force's November and December meetings. The Cochairman said that he would like to work closely with the Governor's Task Force on Health Care to avoid any duplication of recommendations. Another item for discussion at the next meeting is the Catastrophic Health Care Cost Program (CAT). He stated that if the co-chairman agrees and the Task Force is in concurrence, he would like the counties, the CAT fund board, the Department of Health and Welfare and the hospitals discuss on the strength and weaknesses of the current program and ways to improve it. **Cochairman Cameron** invited the Task Force members to let **Mr. Parker** know if there are other subjects that they would like to have discussed and also their availability for the November meeting.

The meeting adjourned at 4:50 p.m.